Jennifer S. Grellman, MS, LMFT
Licensed Marriage and Family Therapist #52905
Adolescent and Family Psychotherapy
810 College Avenue, Suite 1A
Kentfield, California 94904
415-306-6768
jgrellman@comcast.net

Client Information Form – Adult

Name: ____

Date of Birth: ________________ Age: ________ Gender: ________ Marital Status: ________

Address: ____
(Street) (City) (Zip)

Home Phone: ________________ Cell: ________________ Ok to leave message? __________

Email: ______________________________ Best way to contact you? ____________

Occupation: ______________________________ How long? ________________

Name of Employer: ____

Emergency Contact: Name: ____

Phone: ________________ Relationship: ______________________________

I am seeking assistance for (check all relevant boxes):

Individual Counseling ____ Marital Counseling ____ Family Therapy ____ Pre-marital Counseling ____

Divorce Counseling ____ Eating Disorder ____ Drug/Alcohol Use ____ Other ________________

If you are here for reasons other than individual counseling, please list the names, ages and relationships of any other parties who will be participating in the therapy process. (Please note that each individual must also complete a Client Information Form. In the case of minors, a parent or guardian must complete an Adolescent Client Information Form.)

Name: ______________________________ Age: ____ Relationship: ________________

Name: ______________________________ Age: ____ Relationship: ________________

Name: ______________________________ Age: ____ Relationship: ________________

Name: ______________________________ Age: ____ Relationship: ________________

Please describe the main reasons for which you are seeking assistance:

____

____

____

Have you ever received psychiatric or psychological treatment? ________ If yes, please explain why, what type, with whom, and how long the treatment lasted:

____

____

____

Are you taking any medications for emotional or psychological issues? _________ If so, please describe what you are taking, amount of dosage, for how long, and how effective it has been:

____

____

____

Do you have a history of any of the following (please check all that apply):

Suicidal thoughts: _______ Suicide attempts: _______ Domestic Violence: _______ Substance Abuse: _______

Eating Disorders: ________ Other: ____

Depending upon your situation, would you have any interest in participating in a support group?

Is there anything else Ms. Grellman should know in order to assist you?

____

____

____

How were you referred to this practice? ____